

Special Initiatives
Report 14

Making Health-Sector Non-Governmental Organizations More Sustainable: A Review of NGO and Donor Efforts

March 1998

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Partnerships
for Health
Reform

PHR



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Development Associates, Inc. ■ Harvard School of Public Health ■
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Funded by:
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January 1999

Recommended Citation

DeRoeck, Denise. March 1998. *Making Health-Sector Non-Governmental Organizations More Sustainable: A Review of NGO and Donor Efforts*. Special Initiatives Report 14. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

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Contract No.:	HRN-C-00-95-00024
Project No.:	936-5974.13
Submitted to:	Robert Emrey, COTR Health Policy and Sector Reform Division Office of Health and Nutrition Center for Population, Health and Nutrition Bureau for Global Programs, Field Support and Research United States Agency for International Development

Abstract

The paper discusses innovative activities and efforts by indigenous non-governmental organizations (NGOs) working in the health sector that aim to improve their financial, technical, and programmatic sustainability through increased institutional and management capacity. A second section discusses activities that donors and cooperating agencies have undertaken to promote sustainability, including: donor projects aimed at creating NGOs; umbrella or co-financing projects; centrally funded projects that have as a major goal improving the capabilities and sustainability of local NGOs; and sectoral projects that include NGO participation. This review reveals that there is relatively little in the literature on the topic of sustainability of health sector NGOs. Despite the lack of documentation, there appears to be a great deal of interest in the topic of NGO sustainability in the international health and development community. Further research is warranted to provide national governments and local NGOs with information and tools to use as guides in planning the future of NGOs and to help donors and cooperating agencies determine the most effective and appropriate types of technical assistance.

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Acronyms

BASICS	Basic Support for Institutionalizing Child Survival
BEMFAM	Brazilian Family Planning NGO
BMCWS	Bombay Mother and Child Welfare Society
CA	Cooperating Agency
CBD	Community-Based Distribution
CCA-ONG	<i>Coordination des Actions des Organizations Non-Gouvernementales</i>
CEDOIS	<i>Centro Dominicano de Organizaciones de Interes Social</i>
CHAG	Christian Health Association of Ghana
CHAM	Christian Health Association of Malawi
CHDP	Comprehensive Health and Child Development Project
CMAZ	Church Medical Association of Zambia
CYP	Couple Years of Protection
EDI	Economic Development Institute
EPI	Expanded Program on Immunization
FPMD	Family Planning Management Development
GEM	Global Excellence in Management
GK	Gonoshasthaya Kendra
HAVA	Haitian Association of Voluntary Agencies
HMO	Health Management Organization
ICDS	Integrated Child Development Scheme
IEC	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
MAP	Medical Aid Plan
MIS	Management Information Systems
MSH	Management Sciences for Health
MSU	Management Services Unit
MTP	Medical Termination of Pregnancy
MUDE	<i>Mujeres en Desarrollo Dominicana</i>
NGO	Non-Governmental Organization

NPA	Non-Project Assistance
ORS	Oral Rehydration Solution
PCI	Project Concern International
PHR	Partnerships for Health Reform
PIP	PVO/NGO Initiatives Project
PSI	Population Services International
PSS	<i>Parivar Seva Santhsa</i>
PVC	Private Voluntary Cooperation
PVO	Private Voluntary Organization
RUHSA	Rural Unit for Health and Social Affairs
SDS	Sustainable Development Services
SEWA	Self-Employed Women's Association
SHARED	Services for Health, Agriculture, Rural, and Enterprise Development
SSNCC	Social Service National Coordinating Council
SSSS	<i>Saheed Shibsankar Saba Samity</i>
USAID	United States Agency for International Development
USAID/PVC	USAID Office of Private Voluntary Cooperation
VHAI	Voluntary Health Association of India
VHS	Voluntary Health Services

Acknowledgements

This paper is a review based on a literature review and interviews with a number of persons with in-depth knowledge of NGOs in developing countries. One of the major sources of information was a series of NGO case studies on the costs and financing of health care carried out in India by the Ford Foundation and written by Priti Dave Sen. The review also draws upon a series of case studies on local NGOs and private sector organizations conducted by the Initiatives Project. The author appreciates her participation in a case writers' workshop held by the Initiatives Project.

External resource persons who provided helpful information include: Katherine Jones-Patron of the PVC office of USAID; Ann LaFond, formerly with the Aga Khan Foundation; Gerry Rosenthal of MSH; Joe Scalifano and Lisa Hare of the Initiatives Project; Wayne Stinson of URC; David Newberry of CARE; Suzanne Prysor-Jones of the Academy for Educational Development; and Cathy Overholt of the Collaborative for Development Action. The author would also like to thank the following persons who reviewed the first drafts and provided helpful comments: Jim Knowles, Derick Brinkerhoff, Ann LaFond, and Nancy Pielemeier. PHR staffers, Scott Phillips and Jacqui Vera, were also extremely helpful in conducting the literature search and obtaining relevant documents.

Executive Summary

This paper presents an inventory of the types of efforts and activities that indigenous non-governmental organizations (NGOs) working in the health sector are carrying out to become sustainable, as well as efforts of donor organizations to promote sustainability among NGOs. This paper is not an extensive study of the status and level of sustainability of NGOs worldwide, nor will it examine the effectiveness of various strategies that NGOs use to become more sustainable. Most of the information for this review comes from journal articles and documents from the United States Agency for International Development (USAID) and other donor projects, as well as from interviews and discussions with key individuals from USAID, the World Bank, and U.S.-based international private voluntary organizations (PVOs) working with indigenous NGOs in the health sector.

The paper first discusses innovative activities and efforts by NGOs to become sustainable under three main themes: efforts to improve financial sustainability; efforts to improve sustainability through increased institutional and management capacity; and efforts to improve technical and programmatic sustainability. The discussion of efforts to improve financial sustainability is according to the major sources of funding for health sector NGOs: user fees, pre-payment/insurance schemes, national and local government support, commercial schemes, fundraising activities/donations, endowments, contributions by employers or associations, and savings through cost containment and efficiency improvements. Each sub-section provides a brief discussion and examples of the funding mechanism, focusing on the most innovative examples identified by the authors.

In addition to efforts aimed at improving financial sustainability, many health NGOs are trying to improve their sustainability by strengthening their institutional and management capabilities. Examples of these efforts include: creation of NGO umbrella organizations and coordinating bodies, creation of strong leadership bodies, development of strong management information systems, decentralized management, innovative marketing techniques, and strategic and business planning. Finally, examples of technical training programs and other quality control measures are discussed as ways to improve and sustain technical and programmatic capabilities.

In recent years, indigenous NGOs have been increasingly involved in foreign assistance projects. International donor agencies often view NGOs and PVOs as more flexible than government agencies. A second section of the paper reviews activities that donors and cooperating agencies have undertaken to promote sustainability, including: donor projects aimed at creating indigenous, sustainable NGOs; PVO/NGO umbrella or co-financing projects; centrally funded projects that have as a major goal improving the capabilities and sustainability of local NGOs and other private sector organizations; and sectoral projects that include NGO participation.

This review reveals that there is relatively little in the literature on the topic of sustainability of health sector NGOs. More has been written on the sustainability and institutionalization of donor projects and programs or the sustainability of family planning NGOs, especially in Latin America. Despite the lack of documentation, there appears to be a great deal of interest in the topic of NGO sustainability in the international health and development community.

Further research is warranted to provide national governments and local NGOs with information and tools to use as guides in planning the future of NGOs and to help donors and cooperating agencies determine the most effective and appropriate types of technical assistance.

1. Background

1.1 Purpose of Paper

This paper presents an inventory of the types of efforts and activities that indigenous non-governmental organizations (NGOs) working in the health sector are carrying out to become sustainable, as well as efforts of donor organizations to promote sustainability among NGOs. This quick review is the first activity of the Partnerships for Health Reform (PHR)'s Special Initiative focusing on the role of NGOs in health sector reform. This paper is not an extensive study of the status and level of sustainability of NGOs worldwide, nor will it examine in depth the effectiveness of various strategies that NGOs are using to become more sustainable. Exploring these issues would require considerably more research (including field research) than was possible for this initial review.

This review focuses on NGOs that provide primary health services, although some examples of family planning NGOs are given. The focus is also on indigenous NGOs in developing countries, as opposed to international NGOs based in the developed world (such as CARE, Save the Children, etc.)¹.

1.2 Sources of Information

Most of the information for this review comes from journal articles and documents from the United States Agency for International Development (USAID) and other donor projects. One rich source of information was a series of case studies and summary articles of NGOs in India carried out by the Ford Foundation in the late 1980s and early 1990s. A number of articles and reports on the well-known Bolivian NGO PROSALUD were also reviewed. Reports of sustainability of NGOs conducted with USAID funding in a number of countries (Nigeria, Dominican Republic, Togo) were another source of information, as were several reports and articles on USAID-funded NGO umbrella and NGO co-financing projects. A list of references reviewed for this paper is presented in *Annex A*. Because this literature review relies heavily on a limited number of NGO case studies, it is by no means exhaustive.

In addition to the literature review, the author attended a two-day case writer's workshop conducted by the Initiatives (Private Initiatives for Primary Health Care) Project, during which drafts of four case studies of private, non-profit health organizations serving the poor (including two NGOs) were reviewed and discussed in detail. The aim of the case studies is to explore the internal and external factors that lead to the success and sustainability of indigenous, non-profit health organizations. The two NGOs for which case studies have been written are the Guatemalan NGOs Guatesalud and Rxiiin Tnamet. The author also attended a presentation by the Initiatives Project of an assessment of the financial sustainability of 12 health and population NGOs in Nigeria.

¹In this paper, we use the term "private voluntary organization" (PVO) to refer to international private voluntary organizations that are based in developed countries (e.g., Save the Children, and "NGO" to refer to indigenous organizations in developing countries.

A number of individuals from USAID offices, cooperating agencies (CAs) working with indigenous NGOs, U.S.-based international PVOs, and The World Bank were interviewed by phone and e-mail for this paper. These include staff from USAID's Office of Private Voluntary Cooperation (PVC); Peter Berman, who worked on the case studies in India while a resident advisor with the Ford Foundation; staff of Basic Support for Institutionalizing Child Survival (BASICS) and some other CAs; and several World Bank program officers who have been involved in assessing and increasing the role of NGOs on the Bank's projects. PHR has also been in contact with staff of the Sustainable Development Services (SDS) Project funded out of USAID's PVC Office, a project aimed at helping U.S.-based international health, nutrition, and population PVOs and their local affiliates overseas to provide more sustainable services. A PHR staff member (John Holley) presented a case study on the Bolivian NGO PROSALUD at the SDS workshop "Creating Change Strategies for Sustainable Development," held in January 1997 in Northern Virginia. See Annex B for a list of persons contacted for this review.

In addition, PHR staff downloaded correspondence from an electronic conference that Management Sciences for Health's (MSH) Family Planning Management Development (FPMD) Project held initially over a several week period in September and October 1996. The purpose of the SUSTAIN "conference" was to present and discuss a model (matrix) to be used in assessing and developing indicators for the sustainability of population/family planning programs. The conference provided a useful discussion of sustainability and its many interpretations. Correspondence through the conference has continued and PHR is on its "list serve" (mailing list). The FPMD matrix (along with other matrices) can be found in Annex C.

1.3 Definitions

1.3.1 NGOs

The World Bank defines NGOs as "private, not-for-profit organizations that pursue activities to relieve suffering, promote the interests of the poor, protect the environment, or undertake community development" (Hecht and Tanzi, 1993 cited in Waters, 1995). Green defines NGOs as "non-profit-making organizations outside of direct state control" (Green, 1987). These definitions fit the NGOs that were reviewed for this paper, especially in regards to their non-profit status and their social mission to serve the poor and under-served populations. NGOs that fit these definitions include religious organizations (e.g., church-run hospitals), social welfare organizations (e.g., women's groups), and unions and trade or professional associations.

1.3.2 Sustainability

No single definition of sustainability has been agreed upon by development organizations or projects. Several groups define sustainability in terms of an organization's ability to continue to provide services once donor (i.e., international) support is withdrawn. An example of this interpretation is the definition used by the Initiatives Project for their sustainability assessment of Nigerian NGOs. They define sustainability as: "an organization's capacity to continue its institutional structure and production of benefits for its intended client population after the cessation

of donor technical, managerial, and financial support” (Hare, 1996). For the Nigerian assessment, Initiatives considers an NGO financially sustainable if its donor support amounts to not more than 10 to 15 percent of its total revenues, since it assumes that most organizations could cut their costs by this amount through improved efficiency without seriously affecting their programs. The Enterprise Program’s definition is even stricter: “Achieving organizational sustainability means that an NGO can support itself financially through income generated by its commercial activities; no donated funds from outside sources (both private and public) are required” (Fort, 1991). Presumably this includes locally generated donations as well. A further definition of sustainability developed during the FPMD electronic conference is “the ability of an institution to continue to produce in the face of significant external shocks, such as the loss of donor funds.”

Others argue that since the main mission of NGOs is to serve the poor, who are the least able to pay for services, most NGOs will have to continue to depend to some extent on external funding, especially for preventive services and outreach programs, for which people are typically not willing to pay. These individuals define sustainability more in terms of having a diversity of funding sources, including program-generated revenues and outside donations. The FPMD sustainability matrix discussed during the electronic conference defines sustainability in terms of financial stability, namely “stable sources of revenue and committed sources of outside funding.” Some conference participants, however, argued that no funding sources, including USAID, can be considered “stable” today, as donors reduce funding and close country programs. A better indication of sustainability then may be an organization’s capability to raise funds, write good proposals to donors, and so forth. Others argue that an NGO can be considered financially sustainable if it only needs donor funding to subsidize the truly needy.

This range of opinions on what constitutes sustainability makes it difficult to use a single definition for the purposes of this paper. To illustrate this point, the funding sources in 1996 of the Guatemalan NGO Rxiiin Tnamet were Project Concern International (12 percent), the Hewlett Foundation (38 percent), user fees (23 percent), the Moriah Foundation (14 percent), ASINDES (a Guatemalan NGO umbrella organization) (7 percent), the Campbell Foundation (2 percent), Coffee Kids (2 percent), the Population Council (2 percent), and the government-run Social Investment Fund (1 percent). Although less than one-quarter of Rxiiin Tnamet’s revenues are locally-generated (Enterprise’s definition of sustainability), it clearly has a diversity of funding sources. Should this NGO be considered sustainable? As another example, a number of NGOs in India and other countries are heavily funded by their national or state government (through grants, subsidies, provision of free government employees and medicines, etc.), and may even be responsible for all health services in selected districts or regions. Should these NGOs, given the uncertainty of the government funding in many countries, be considered financially sustainable?

A number of sources identify three main elements critical to an NGO’s sustainability (Farrell, Bratt and Canuza, 1993; SDS Project documents, 1996). These are:

- ▲ **Financial Sustainability**, which can include strong financial management and control (including good cost accounting systems), a significant portion of core costs covered by locally generated resources (e.g., user fees, regular fundraising, commercial ventures, and other income-generating activities), a diversity of funding sources, financial planning capability, existence of an investment strategy, etc;

- ▲ **Institutional/Management Capacity**, which includes such elements as a clear organizational structure, a strong board of directors, strategic and business planning ability, sound management practices and well-functioning administrative systems (including management information systems), and marketing skills to be able to expand services; and
- ▲ **Technical or Programmatic Capacity**, which includes the ability and commitment to provide high quality services, ongoing staff training and assessment, the existence of clinical standards and other quality assurance measures, and information, education and communication (IEC) programs.

1.4 General Findings from this Review

Some general findings are:

- ▲ There is relatively little in the literature on the topic of sustainability of health sector NGOs. More appears to have been written about the sustainability of donor projects and programs and efforts to institutionalize them, as a result of recent declines in USAID and other donor funding. More literature exists on the sustainability of family planning NGOs, especially those in Latin America supported by donor funding. This lack of literature points to a need for more information to be gathered and disseminated on this topic.
- ▲ There appears to be a great deal of interest in the topic of NGO sustainability in the international health and development community.
- ▲ Further research on health sector NGO sustainability is warranted to provide national governments and local NGOs with information and tools to use as guides in planning the future of NGOs and to help donors and cooperating agencies determine the most effective and appropriate types of technical assistance. Areas of needed research include: how to assess the sustainability of NGOs (and the development of assessment tools); examining what factors or characteristics of an NGO are crucial to its success and ultimate sustainability; examining the effects of various government policies and regulatory provisions on the sustainability of NGOs; determining which types of activities have been successful in achieving sustainability and which have not and why; and developing indicators of sustainability for health sector NGOs to complement the work being done by several population CAs on family planning sustainability indicators.

1.5 Characteristics of the NGOs Included in this Review

The NGOs included in this review vary considerably in their size, the number of people they serve, their origins, the types of services they provide, their funding sources, and the diversity of their funding. Some, especially several in India and Bangladesh, serve hundreds of thousands of people. For example, the Tribhovandas Foundation, which works through milk cooperatives, served 800,000 people in the late 1980s. Most of the NGOs found in this review, however, serve considerably less than this and most work in a limited geographical area (i.e. a district or region), although a few, like BRAC in Bangladesh provide services nation-wide.

The majority of NGOs included in the review focus on delivering primary health and preventive care services through community-based clinics, outreach activities, or both. Some, like Guatesalud in Guatemala, provide primary health care services exclusively through a network of health promoters backed up by doctors who treat common illnesses and refer more serious cases. Many NGOs have clinics or hospitals in addition to providing community-based services through outreach activities or through smaller units, such as health posts, “mini-clinics,” or dispensaries. Typical of this pattern is the Indian NGO, Voluntary Health Services (VHS) in Madras, which has a 240-bed hospital on the outskirts of the city of Madras, as well as a rural program providing primary health care services for 160,000 people through 32 village-based mini-clinics. Most of the NGOs included in this review provide health services only, although some, such as Self-Employed Women’s Association (SEWA)-Rural in Jhagadia, India and *Mujeres en Desarrollo Dominicana* (MUDE), an NGO in the Dominican Republic, conduct other development activities as well, such as micro-enterprise and credit programs, rural development projects (e.g., SEWA-Rural’s “Social Forestry Project” through which landless laborers and small farmers receive degraded forest land for reforestation) and educational and vocational training programs.

Local religious organizations, worker associations, or other indigenous groups/individuals created a number of NGOs as social enterprises. This is true of most of the Indian organizations studied for this review. Others were created by international donor projects and have since become autonomous organizations. These include PROSALUD in Bolivia, which was the USAID-funded Self-Financing Primary Health Care Project; Rxiin Tnamet, a small Guatemalan NGO that began as a Project Concern International project; and a number of population NGOs that were created through USAID financial and technical support. In addition, a large number of local NGOs were founded by or built up with assistance from international PVOs, such as CARE and International Planned Parenthood Federation (IPPF), and have since become independent organizations.

Diversity and sources of funding vary considerably among the NGOs reviewed. Several of the Indian NGOs are totally community-financed through user fees, pre-payment schemes, membership fees, etc. Many Indian NGOs, however, are heavily dependent on government funding, including funding from donors channeled through the government. Other NGOs, such as ADOPLAFAM in the Dominican Republic, are almost entirely funded by international donors.

NGOs that offer clinic or hospital-based curative care services are more likely to receive a significant portion of their revenues from community-financed sources than those that provide mainly outreach and preventive services. In cases where NGOs provide both hospital and community-based (i.e., outreach) services, a significant portion of the hospital cost is recovered by user fees or other community financing mechanisms, while the community-based services are largely donor-funded. Little cross-subsidization from the hospital to the community services occurs. For example, in 1987-88 less than 9 percent of the total income received in by the hospital run by the Indian NGO, VHS, came from donors (USAID) and 70 percent of its income came from patient collections and interest earnings. On the other hand, 73 percent of the income of VHS’s community-based primary health care program came from USAID, while VHS’s hospital provided only 8 percent of the program’s funding. The Guatemalan NGO Guatesalud has a network of largely farm-based clinics and health promoters that is financed entirely by contributions from the farm workers’ employers and consultation fees.

1.6 Common Obstacles to Achieving Sustainability

NGOs providing health services encounter a number of common obstacles to achieving sustainability. Several of the obstacles stem from the conflicting goals of NGOs to both serve those who can least afford to pay for health care while at the same time attempting to achieve a high level of self-financing through user fees and other means of community financing (Fiedler, 1990). NGOs that serve primarily the very poor are often limited in their ability to raise funds within the communities they serve. When fees were increased at the Rxiiin Tnamet clinic, located in Santiago, Atitlan, in Guatemala, many clients stopped going. Even though the consultant fees remained much lower than those charged by private physicians and pharmacies, they still represented half of a typical worker's daily wage, even before the costs of medicines and lab tests were added. The perceived mission of the NGO among the population was also a critical factor. The former clients of Rxiiin Tnamet continued to view the organization (which had begun as a Project Concern International (PCI) project) as a project aimed at serving the poor and thus felt that it had abandoned its mission by charging unaffordable rates, which they refused to pay. Another conflict arises from the focus of many NGOs on providing preventive care services, which people are often less willing to pay for than curative care. A further set of conflicting goals involves expanding services to increase coverage versus the desire to keep the organization and service priorities "manageable."

In addition to these inherent conflicts, other common characteristics of NGOs make it difficult for them to achieve sustainability. For example, since NGOs are usually founded as social enterprises or charities, often with donor funding, they tend to lack a business orientation, as well as strong planning and management capabilities and systems. They are often founded by groups or individuals with strong technical skills and/or a background in the social services, as opposed to those with strong management or business backgrounds. Another common feature is their reliance on volunteers, who can provide a strong link to the communities and be a major source of motivation, but often turn over quite rapidly, especially when they receive little or no financial incentives.

There are a number of features of NGOs that are conducive to sustainability. These include: the perception that the quality of care that they provide is considerably higher than that provided by the government and thus the demand for their services is higher; non-bureaucratic and flexible style of operation, which can allow them to more readily experiment with innovative service delivery programs and financing mechanisms; close links with the communities they serve; and "motivational force" in harnessing a spirit of volunteerism and service (Gilson et. al, 1994).

Despite these strengths, a main finding of this review is that many of the NGOs studied are operating within very narrow financial constraints and often seem to be on the verge of going bankrupt. Even those that appear to be operating within their means or at a surplus were found in case studies to be operating at a deficit when capital depreciation and maintenance costs were factored in (VHS & SEWA-Rural case studies; Hare, 1996). Fluctuations and reductions in donor funding in recent years are a major factor, as well as the inherent problems previously outlined. The increasing uncertainty in funding has led a number of NGOs to experiment with innovative approaches towards achieving financial, institutional, and technical sustainability.

2. Innovative Activities and Efforts of Health NGOs to Become Sustainable

2.1 Efforts to Improve Financial Sustainability

The major sources of funding for NGOs working in the health sector are:

- ▲ User fees
- ▲ Pre-payment/insurance schemes
- ▲ National and local government support
- ▲ Commercial schemes (income-generating activities)
- ▲ Fundraising activities and private donations
- ▲ Endowments
- ▲ Contributions by employers or associations
- ▲ Savings through cost containment measures and efficiency improvements
- ▲ International donor support

This section does not discuss financial support by international donor agencies. A discussion of donor-supported efforts to improve the sustainability of health sector NGOs can be found in *Section 3.0*. The subsections below give examples of each of the types of funding mechanisms listed above (with the exception of international donor funding), focusing on the most innovative.

2.1.1 User Fees

User fees are the single largest source of revenues for several of the more sustainable health NGOs reviewed for this paper. This is especially true for NGOs that provide hospital care and/or a substantial amount of curative care services (often in urban settings) as opposed to mainly community-based preventive care. For example, user fees in 1987 covered 94 percent of the clinic operating costs, and 55 percent of total program income of *Parivar Seva Sanstha* (PSS), an Indian NGO that provides reproductive health service—mainly abortions and sterilizations—through 22 urban-based clinics operating in eight states (Dave, 1990c). User fees for curative care recover between 60 and 110 percent of direct operating costs at PROSALUD's clinics, and accounted for approximately 42 percent of total program costs in 1996, including central management costs. This contrasts with organizations that largely provide community-based services in rural settings, such as

SEWA-Rural in India and Rxiiin Tnamet in Guatemala, for which user fees account for only nine percent and 23 percent, respectively, of total program revenues (Dave, 1990b; Strohlic, 1996).

NGOs often charge user fees for curative care services. These fees can include registration fees, consultation charges, fees for drugs and laboratory services, and a daily bed charge for inpatient care. NGOs that have pre-payment schemes (discussed below) often charge small co-payments for clinic visits or drugs. Some organizations with insurance schemes, such as RAHA, an Indian federation of Catholic church-run hospitals and health centers, charge non-members commercial rates for services and drugs; these non-member charges at RAHA constitute a major proportion of total revenues (Dave, 1991). Preventive care services are typically provided free-of-charge, as discussed below, although there are some interesting exceptions. The Bombay Mother and Child Welfare Society (BMCWS), which operates two maternity hospitals with child welfare centers, began to charge a fee of Rs.5 for immunizations that had previously been provided free and saw their immunization follow-up rate increase from 50 percent to 90 percent upon the introduction of this fee (Dave, 1991).

Cross-Subsidization and Means Testing

Many of the interesting innovations concerning user fees relate to methods of cross-subsidization and means testing that NGOs are using in order to continue to serve the poor and at the same become more financially sustainable. Examples in the literature of three common types of cross-subsidization involving user fees are given below:

▲ Cross-Subsidization by Income Group

Many NGOs provide free services to the poor or have a sliding scale for fees according to income level. The percentage of clients receiving free care for chargeable services ranges considerably – from around 10 percent of all patients at PROSALUD in Bolivia to approximately 60 percent of outpatients using the referral hospital of SEWA-Rural, which is located in a poor tribal area of India. Most of the NGOs providing hospital services offer higher priced special wards, which are smaller and more private, and some even offer separate “private” facilities on the hospital premises, for which patients are charged higher (and even commercial) rates. The Aravind Eye Hospital in Tamil Nadu in India, for example, has two separate facilities—one that provides totally free care and one that charges patients. The only difference between the two facilities is the quality of ‘hotel’ services (e.g., room, degree of privacy, bathroom facilities, etc.), while the quality of health care in the two facilities is identical (Dave, 1991). In some cases, cross-subsidization between the different classes of wards or facilities clearly takes place, as in the case of the “deluxe unit” (private nursing home) of the hospital run by VHS in India, where cost recovery was estimated in 1987-88 at 264 percent (Dave, 1990a). In other cases, such as SEWA-Rural in India, cross-subsidization is absent, since the charges for its special ward do not cover costs and thus the ward is adding to the organization’s deficit, instead of subsidizing poor patients.

▲ Cross-Subsidization by Geographic Area

Another means that several health NGOs use to have better-off patients subsidize care for the poor is to locate facilities in both middle-class and poor areas and to have the middle-class facilities subsidize those located in poorer areas. This cross-subsidization can occur by clinics charging higher fees in the wealthier areas and by the fact that the demand for chargeable services is greater in the wealthier areas. This type of subsidization has been successful at PSS in India, where clinics

operating at a surplus in the wealthier neighborhoods (130 percent in one case) subsidize those in poorer areas operating at a loss (50 percent in another case) (Dave, 1990(c)). Several family planning NGOs supported by the former USAID-funded Enterprise Program, including YKB in Indonesia and CEPECS in Brazil, established upscale, revenue-generating clinics in middle-class areas with the intention of subsidizing clinics in poorer areas, though how successful they have been in doing so is not known (Fort, 1991). The Bolivian NGO, PROSALUD, purposely established clinics in better-off areas of La Paz to subsidize those located in the nearby poorer area of El Alto (Holley, 1996).

▲ Cross-Subsidization by Type of Health Care Service

A number of NGOs provide preventive health services free of charge, while charging for curative care (either outpatient or inpatient). Some NGOs, such as PROSALUD, provide preventive and curative care services at the same facilities, while others have separate outreach programs in the communities for preventive care. Rxiin Tnamet in Guatemalan provides reproductive health, diarrheal disease control, and Expanded Program on Immunization (EPI) outreach services in the community, including door-to-door immunization campaigns and community-based oral rehydration solution (ORS) distribution, as well as curative care services through its town-based clinic. However, few examples were found in the literature of curative care services actually subsidizing the costs of preventive care. In most cases, the curative care activities are themselves barely, if at all, self-supporting, and the preventive and outreach activities are paid largely by government grants (in the case of SEWA-Rural, India) or external donor funding (in the case of VHS, Rxiin Tnamet, and several others). One exception is the Aravind Eye Hospital in India, which generates enough of a surplus from user fees to pay for free outreach care through rural eye camps (Dave, 1991). VHS in India is one of the few organizations found in the literature which makes formal transfers of funds from its hospital account to support its community-based services. These funds, which make up eight percent of total revenue for the community program, come from the profits of the hospital's income-generating services, such as diagnostic and lab services (Dave, 1990a).

PROSALUD has developed an innovative means of subsidizing preventive care with services provided on a fee-for-service basis by three types of specialists (pediatricians, ob/gyns, and dentists). These specialists split their fees with the organization and receive no salaries, thus keeping costs low. In the early 1990s, the services provided by these specialists accounted for a substantial portion of the revenues that PROSALUD generated, the single largest net income generator being deliveries—allowing the organization to provide a substantial amount of free preventive care, which accounts for 40 percent of all patient visits (Fiedler, 1990).

The sale of drugs at a profit, as well as ancillary services such as laboratory services and diagnostic centers, are a means by which many health NGOs generate funds to subsidize preventive health care and other services for poor patients. These activities are discussed further in Section 2.1.4 (“Commercial Schemes”).

In the area of means testing, most NGOs provide free or lower-cost services to poor clients. Ability to pay is often determined informally, either by a series of questions (on income level, number of children, area of residence, etc.) or by the patient's appearance, and is often at the discretion of the administrative staff, doctor, or other type of health care worker. The proportion of fees that indigent patients pay can be determined by formal sliding scale systems, such as that used by the VHS hospital in India, which has four fee levels corresponding to income categories, or may be determined less formally. The subsidies given to poor PSS patients, for example, can range from 5

percent to almost 100 percent of total costs (Dave, 1990c). Depending on the NGO, total or partial subsidies are given for services, drugs, or both.. RAHA has implemented an interesting and innovative variation on means testing; it charges its referral hospitals different entrance fee levels for members of its pre-payment scheme based on the distance the patient has traveled. The lowest of the three levels—Rs.100 for members traveling more than 100 km—is half of that paid by members traveling less than 25 km (Dave, 1991). No examples were found in the literature of NGOs accepting in-kind contributions for consultations, drugs, or other services as a replacement for user fees, probably due to logistical and management problems.

Several NGOs have instituted innovative methods of ensuring equity, such as means testing systems and in-kind contributions, as part of pre-payment schemes, which are discussed in the following section.

2.1.2 Pre-Payment and Insurance Schemes

A number of NGOs, including several in India, offer pre-payment or insurance programs, either through employers, associations, and organizations or to households and individuals.

An interesting employer-sponsored program is run by Guatesalud, a small NGO started by two physicians (an American and a Guatemalan) to provide preventive and curative health services to Guatemalan farm workers and their families living on large coffee farms (*fincas*) and other kinds of large agricultural estates. Guatesalud enters into contracts with farm owners (“client-sponsors”), who pay up-front a monthly charge (Q900 or approximately \$150 at 1996 exchange rates) per 500 workers to cover services provided by health promoters and doctors operating from farm-based clinics. (*Fincas* with more than 500 workers pay an additional Q900 per month.) The health promoters, recruited from the farm community itself, each work full-time in one clinic, whereas the doctors cover several clinics each. In addition to the monthly fee, farm owners are required to pay for the promotor’s one-month training and monthly salary, an initial stock of drugs and equipment, and replacement stock (the costs of which in theory are recovered by user fees). This system allows the client-sponsors, as opposed to Guatesalud, to assume the financial burden of supplying drugs. Farm workers and their dependents pay a fee for consultations as well as for medicines; the promoters are allowed to keep the consultation fees they collect, whereas the physicians turn their fee over to the client-sponsors. The program was designed to be totally self-financing and to operate as a business. It has not received any outside funding, but has received technical assistance in management and strategic planning from the USAID-funded Initiatives Project. Guatesalud, however, has experienced serious financial difficulties, stemming from farm owners delaying payments for monthly fees or medicines or pulling out of the program altogether when coffee prices declined. As a result, it has often been on the verge of closing.

Other pre-payment schemes are sponsored by associations or other groups, such as the Tribhovandas Foundation in Gujarat state, India, which is run by milk cooperatives. Voluntary insurance schemes offered to individuals and households include VHS’s Medical Aid Plans (MAP), offered through both its hospital and community-based health program, and pre-payment schemes run by the Indian NGOs, RAHA and Sewagram. Some of these schemes provide free community and hospital care to their members, while others offer reduced charges for drugs and for hospital care (though outpatient visits are generally free). VHS, for instance, offers two separate MAPs, one for its hospital services, which entitle all members to reduced fees for inpatient hospital care, and members

in the lowest income category to free inpatient care, and one through its community-based network of mini-health centers, which provides members with free community care and free or reduced-rate hospital care. RAHA, provides members of its pre-payment scheme (after they pay a small entrance fee) free hospital services up to a ceiling of Rs.1,000, in addition to free community-based services and drugs.

Most of the pre-payment schemes run by NGOs described in the literature are not very successful as a means of raising revenues, and their membership fees often bring in a relatively small proportion of total income. One of the reasons for this is that many of the plans offer membership fees on a sliding scale according to ability to pay, and the majority who join tend to be the poorest. This is true of the VHS hospital-based MAP; most of its members in 1987-88 belonged to the lowest income category, and pay an annual fee of only Rs.12 (versus up to Rs.300 for the wealthiest members), while receiving care totally free-of-charge.

Another common reason for the lack of success of these programs is that many do not require a waiting period before joining, and thus people tend to join only when they are ill. The membership fees therefore serve as an entrance fee for reduced-price services and people tend not to renew their memberships once they are well. This is the case with the Lalitpur Community Development and Health Programme in Nepal, where a ticket bought at any time entitles a family to free care at health posts and, if referred, at the main hospital. This interest in joining such schemes only when ill is a main reason for the very low enrollment rates of VHS's community-based MAP provided through mini-health clinics. Sewagram in India, which operates two community outreach programs and a 500-bed hospital in Maharashtra state, has an innovative method of minimizing this type of adverse selection. The program is only offered to villages after 75 percent of its households have enrolled in the scheme. Membership fees cover 96 percent of its community costs (e.g., salary of community health worker, drug, and mobile support costs), versus the much smaller percentage of cost recovery achieved by most other NGO-run schemes (Dave, 1991).

A third reason for the limited success of these schemes is that they may encourage over-utilization of services by their members, due to a lack of restrictions on care and a lack of co-payments. This was a principal reason for the failure of the pre-paid care scheme started by PROSALUD in 1986, which only lasted a short period of time (Fiedler, 1990).

Some of the pre-payment schemes in India offer services to non-members at prices that apparently exceed costs, resulting in non-members subsidizing the services of members. RAHA, for example, charges non-members commercial rates for doctor consultations and drugs. These fee collections from non-members, in fact, constitute a major source of income for the health centers, whereas membership fees cover only a small proportion (10-20 percent) of total community costs (Dave, 1991).

Methods of Ensuring Equity

Some of the NGO pre-payment schemes have innovative approaches towards protecting the poor through both means testing systems and the acceptance of in-kind contributions, as described below.

▲ Means Testing

Several of the Indian NGOs studied by Dave have sliding scales for membership fees. The fee schedule for VHS in Madras is particularly progressive. There were, until recently, five income categories, and annual fees for the wealthiest patients could be as much as 25 times higher than for those in the lowest income category (fees range from Rs.12 to Rs. 300). User fees and co-payments for hospital services for VHS members also differ substantially by income group, with members in the lowest category receiving all inpatient services free of charge after they pay a small admission fee. The rate of cost recovery for inpatient services, based on average receipts per bed-day (excluding lab charges and operations), ranges from as little as 1.7 percent for the poorest members to 60 percent for patients in the second highest income category, and 146 percent for the wealthiest non-members. However, as mentioned above, little cross-subsidization between income groups actually takes place, since the program mainly attracts the poor; 92 percent of members in 1987-88 belonged to the two lowest categories versus only 0.8 percent in the highest income group. Consequently, income from membership fees accounted for only four percent of the hospital's total income in that fiscal year. The NGO has recently simplified the system and reduced the number of categories, since objective evidence of income is usually absent and judgements on income level are based instead on appearance and other informal measures (Dave, 1990a; Berman and Dave, 1996).

Sewagram in India has devised an interesting means of determining ability to pay in a rural society where steady wage income is rare. A sliding scale for membership fees is based on four socio-economic groups, determined by what property the household owns (land vs. no land, irrigated vs. unirrigated land, and whether or not they own a pair of bullocks) as well as whether or not they employ contractual farm labor. The communities themselves established these categories through a village committee. The result that 96 percent of the program's community costs, as mentioned above, are covered by membership fees demonstrates the success of this means testing system in that region (Dave, 1991).

▲ In-kind Membership Fees

Several of the schemes described in Dave's study offer members the option of paying the annual fees in-kind instead of with cash (Dave, 1991). The Sewagram program, for instance, accepts fees in sorghum, collected once a year during harvest time with amounts varying in accordance to the four socio-economic groups described above. The RAHA scheme and the small Goalpara Cooperative Health Society in West Bengal, which runs a dispensary, accept membership fees in the form of rice. Goalpara also accepts labor as a means of payment. The grain contributions are collected once a year and can be sold by the NGOs in bulk, making the handling of them manageable.

2.1.3 Government Support

Local and national governments constitute an important source of funding for many health and population NGOs in developing countries. Government support can range from in-kind donations to tax exemptions to various kinds of direct financial support, and it is not uncommon for an NGO to receive several types of government support at the same time. The major types of government support found in the literature are in-kind donations, direct financial support, tax subsidies and other exemptions, and contracting out health services.

In-Kind Donations

Many examples were found of local and national governments providing contributions to health NGOs in the form of government staff (or paying for staff salaries), drugs, medical supplies, equipment, and facilities. In several African countries, governments either second staff to church-run NGOs, as in Uganda, or pay their staff salaries, as is the case for all church-affiliated health staff in Ghana and Malawi (Gilson et al., 1994). In Malawi, local staff salaries account for most of the government's contribution to church-run facilities under the Christian Health Association of Malawi (CHAM), which made up more than one-third of CHAM's total revenues (including user fees) (Banda and Simukonda, 1994). In Tanzania, the government seconds staff to NGO-owned hospitals that are designated as district hospitals (Gilson et al., 1994). The Ministry of Public Health of Bolivia formally subsidized the staff salaries in several of PROSALUD's clinics located in rural areas.

Among the numerous examples of governments providing other inputs to NGOs on a regular basis, the Ministry of Health in Guatemala provides Rxiiin Tnamet with medical supplies for its preventive health outreach services, including vaccines and oral rehydration salts. The Government of India provides in-kind assistance to PSS in the form of contraceptives, vaccines, and folic iron tablets (Dave, 1990c). In Ghana, the government provides the buildings for "agency" hospitals, which are run by NGOs, as well as equipment, drugs, and financial support (Gilson et al., 1994). PROSALUD has also benefited from free buildings for several of its clinics provided by the Bolivian Ministry of Public Health.

Direct Financial Support

The various forms of government financial support to health NGOs can be categorized into the four following groups:

- ▲ Earmarked Grants or Subsidies

A number of NGOs receive local or national funding for specific health activities and services, especially preventive health services. The state government of Tamil Nadu, India, for example, pays part of the costs of family planning services provided by VHS's hospital. The government of India provides a grant to PSS for the maintenance of family planning beds and to pay patients cash incentives for acceptance of family planning. The Indian government also covers all costs of the NGO's mobile health project in rural areas of Haryana state.

- ▲ Seed Funding for the Start-Up of Services or Activities

An example of a government providing funding for start-up costs is the case of PSS in India, where the central government provides 75 percent of the costs of starting a new clinic. The government continues to fund the clinics' recurrent costs on a declining scale for five years, after which the organization takes full financial responsibility (Dave, 1990c).

▲ General Budgetary Support

NGOs in a number of countries receive general support, as opposed to earmarked funding, from national and local governments. In some cases, such as with the church-run health NGOs in Papua New Guinea, this support can be so substantial that these services are often viewed as “part of the public health sector” (Gilson et al., 1994). One common form of government support to NGO hospitals is a “bed grant,” in which the government provides funding on the basis of number of beds, ostensibly to cover the costs of indigent patients. This is the case in Tanzania, where the government provides Tsh 1000 (around \$2) per approved bed to NGO hospitals designated as district hospitals (Gilson et al., 1994). The government of Tamil Nadu accepts the responsibility of contributing to the maintenance costs of the VHS hospital on a per-bed basis, since there are no government health facilities in the area. The government contribution is supposed to cover 50 percent of the VHS hospital’s recurrent costs, although a financial analysis found that it actually covered only around 20 percent of these costs in 1989 (Dave, 1990a). Another example of general government support to NGOs is a “deficit grant,” in which the government of India pays for a significant amount of the NGO’s annual gap between expenditures and revenues as a means of compensating the NGO for providing free care to the poor (Berman and Dave, 1996). In some parts of India, NGO hospitals receive a government subsidy for using an exemption mechanism for poor patients (McPake and Banda, 1994).

▲ Tax Subsidies and Exemptions and Other Subsidies

NGOs in Nepal receive tax exemptions for health commodities and services on the recommendation of a national NGO umbrella group. In Ghana, members of the Church Health Association of Ghana (CHAG) are exempt from paying import duty on medical supplies and equipment (Gilson et al., 1994). Church NGOs in Malawi benefit from a different type of government subsidy by buying drugs from the government’s central medical store at subsidized rates (Gilson et al., 1994).

▲ Contracting Out Services to NGOs and NGO Management of Local Health Services

In some countries, NGO-run hospitals have been designated by national governments as district hospitals responsible for providing hospital services for the entire district, for which they receive grants, subsidies, and other support from the government. This is the case in Tanzania, where a number of privately-owned mission hospitals are Designated District Hospitals, which receive heavy government subsidies and are managed by boards made up of government and church representatives (Gilson et al., 1994). Given the heavy involvement of government in financing and operating these hospitals, however, they are often considered public providers (Munishi et al., 1995). In Nepal, one church-run hospital has been designated as a district hospital and receives government funding to cover around three percent of its operating costs (Gilson et al., 1994).

In Malawi, church-run hospitals affiliated with CHAM have been given responsibility for managing all health services, including those provided by the government, in 15 of the country’s 39 newly-created Health Delivery Areas. It is hoped that this arrangement will improve the overall management of the health system and will allow for cross-supervision between government and NGO providers (Banda and Simukonda, 1994; Gilson et al., 1994).

An example of a government contracting out health services to an NGO is the arrangement between the state government of Gujarat in India and the NGO, SEWA-Rural. The government provides a block grant to SEWA-Rural to assume the responsibility of providing community-based health services in Bharuch district covering 40 villages with a total population of 35,000. These services are provided through 10 health sub-centers that offer maternal and child health and family planning services and were turned over to SEWA-Rural by the government in the mid-1980s. In addition, the state government handed over to SEWA-Rural responsibility for its Integrated Child Development Scheme (ICDS), in which pre-school care workers (anganwadi workers) provide preventive care and nutrition services to children and mothers in the same block. The state government fully funds this program (Dave, 1990b).

Health NGOs have encountered a number of common problems with government support. These include delays or even non-payment of grants and reimbursements, which is increasingly a problem as economic conditions decline in a number of countries, low and inflexible reimbursement rates (e.g., for bed grants), the lack of flexibility in the use of earmarked funds, and unacceptable conditions tied to the granting of funds. For instance, in Zimbabwe the government prescribes fees in church-run hospitals that the missions consider too high (Gilson et al., 1994).

2.1.4 Commercial Schemes (Income-Generating Activities)

Although user fees and membership dues constitute, by far, the largest sources of community financing (as opposed to government or donor financing) for health NGOs, a number of these organizations supplement their income with various commercial schemes or income-generating activities. However, these schemes often involve heavy investments in cash, time, and energy, and consequently, their contribution to health programs is often negligible. Cagnon recommends that, as a general guideline, NGOs should estimate that only five percent of the total revenues generated by income-generating activities will be available to subsidize the NGO's other programs (Cagnon, 1982 cited in Hare, 1996).

Unless otherwise noted, the financial performance of these commercial activities was not indicated in the available literature. These activities can be divided into: manufacture and/or sale of medicines and other health-related products, profit-making health-related services, sale of training, technical assistance and research services, and non-health related business micro-enterprises.

Manufacture and/or Sale of Medicines and Other Health-Related Products

Although most NGOs considered in this review sell drugs to their patients, either at a subsidized price, at cost, or at a small mark-up, some operate larger scale commercial pharmacies and even drug factories as a means of generating profits. Examples include:

- ▲ The Bangladeshi NGO, Gonoshasthaya Kendra (GK), which produces and markets generic drugs;
- ▲ The well-known Indian labor union, SEWA (Self-Employed Women's Association) of Ahmedabad, which operates a commercial pharmacy that sells largely generic drugs at limited mark-ups. The profits from its pharmacy are used to support the organization's health outreach programs;

- ▲ Voluntary Health Association of West Bengal, which operates a wholesale drug operation that buys large quantities of drugs, conducts testing and quality control procedures, and sells them at subsidized prices to other NGOs throughout West Bengal (population 80 million);
- ▲ A small eye glass factory owned by PROSALUD, eventually expected to provide some income; and
- ▲ An optical shop owned by doctors of the Aravind Eye Hospital in Tamil Nadu, India, whose profits are distributed to the doctor-shareholders as an incentive to offset their low salaries.

The social marketing of contraceptives has provided many NGOs offering family planning services with a steady, although often relatively small source of income. Some social marketing programs, however, do provide an important source of income. The extensive program run by the Dominican NGO, PROFAMILIA, which sells condoms and pills through community-based distributors and drugstores, generated revenues that covered 23 percent of total program expenditures in 1992 and 66 percent of service delivery expenditures (Farrell et al., 1993). PROSALUD runs a national social marketing program that sells condoms and pills at low cost through the commercial sector, including non-traditional outlets such as grocery stores and neighborhood markets. There are few examples in the literature of the social marketing by NGOs of health products other than contraceptives. PROSALUD, however, plans to expand its social marketing program to sell ORS, antibiotics, vitamins, and mosquito nets.

Profit-Making Health-Related Services

Examples of for-profit health-related businesses established by NGOs to help finance their health programs include:

- ▲ Laboratory and diagnostic centers, that often provide services to other providers and the general public, as well as to their patients. A large Brazilian family planning NGO, BEMFAM, which operates a low-cost cervical cancer screening lab started with USAID support, has contracts with two of the country's HMOs and provides services to private physicians. In India, the diagnostic center, run by the VHS hospital but located in a separate neighborhood, provides laboratory investigations for private physicians and the general public at commercial rates. The Hospital Sofia Feldman provides child health and family planning inpatient and outpatient services to a population of 300,000 in Brazil and runs a laboratory that generates enough funds to cover 40 percent of the hospital's family planning expenditures (Fort, 1991).
- ▲ The Bombay Mother and Child Welfare Society (BMCWS) which operates two maternity hospitals with child welfare centers and includes a for-profit convalescent home for cancer patients undergoing protracted cancer therapy and their families.

Sale of Training, Technical Assistance, and Research Services

NGOs sometimes generate revenues by providing technical assistance, training, and research services to other NGOs, private employers, and governments. Some examples are:

- ▲ Child in Need Institute in Calcutta, which runs a commercial consultancy firm that carries out health research and evaluation work, the profits of which are used to support its health programs; and
- ▲ PROSALUD, which generates some income by charging organizations from other countries interested in establishing similar programs for visits to observe and learn about its operation. PROSALUD has charged Peruvians (who set up a similar scheme called MAXSALUD), Brazilians, and Zambians, among others. PROSALUD is also in the process of entering an agreement with Population Services International (PSI) to assist in the development of a network of private clinics in Zambia, based on the PROSALUD model.

Non-Health Related Businesses/Micro-Enterprises

These can range from employment and economic development schemes to credit programs to other types of non-health related businesses. A few examples include:

- ▲ A pilot scheme run by SEWA-Rural in India to provide employment opportunities for rural women, and the NGO's technical training program that trains rural youth in such skills as welding, carpentry, and automobile maintenance and assists them with job placement. Income is generated for the organization from the sale of papad and the paid commercial work that the trainees undertake. However, as of 1987-88, both programs were still operating at a deficit.
- ▲ A day-care center run by BMCWS that provides creche, nursery, and school facilities in an affluent area of Bombay. Monthly attendance fees and an initial entrance fee are invested in fixed deposits that provide the society with steady interest earnings. Surpluses from the program are used to finance health services as well as other day care centers in poor areas.
- ▲ Child in Need Institute in Calcutta, India which operates a range of commercial schemes, including a chicken farm, a brick-making operation, and the production and sale of greeting cards.

2.1.5 Fundraising Activities and Private Donations

These activities focus on charitable giving versus commercial sales of products and services. Some examples include:

- ▲ Private domestic donations from individuals, private businesses, and charitable organizations. These can be collected in the form of subscriptions to societies run by the NGO, as is the case with the Indian health NGO, *Saheed Shibsankar Saba Samity* (SSSS), which accepts annual and lifetime membership from individuals and private businesses, and the VHS hospital, whose General Society collects membership subscriptions.

- ▲ Fundraising events, which include charity plays and fairs put on by the Indian NGO, Goalpara in West Bengal; urban-based cultural programs such as concerts sponsored by SEWA-Rural; and walks sponsored by the Indian organization Students Home Health.
- ▲ In-kind contributions, including volunteer labor from community members and from medical professionals. One example is that of VHS, where 48 part-time medical officers providing services in the hospital receive only a “conveyance” allowance, and 29 honorary medical officers receive no compensation. The market value of their donated services was estimated to be equivalent to almost 14 percent of the organization’s total revenue in the late 1980s (Dave, 1990a; Berman and Dave, 1996).

Although cash donations raised domestically usually constitute a very small source of income (e.g., about one percent in the cases of the VHS Hospital and PSS), there are some exceptions. Total private donations to SSSS, including society subscriptions, represented 45 percent of the organization’s total income in the late 1980s (Dave, 1991). Another exception is SEWA-Rural, which collects donations domestically from private institutions, individuals, and charitable trusts, as well as from fundraising events. These local private donations made up 13 percent of the SEWA-Rural’s total revenues used for medical and health-related activities in the late 1980s, and helped make up for the relatively small contribution from the patient fees (less than 13 percent) that this rural, preventive care-oriented NGO serving a largely impoverished population was able to collect (Dave, 1990b). The experience of SEWA-Rural suggests that domestic donations as a source of funding have not been sufficiently tapped by many health NGOs, even those that serve primarily poor populations.

2.1.6 Endowments

An endowment is essentially a sum of money that is invested to generate income. There are different types of endowments: those that restrict the organization to spending interest income and never touching the principal and those called term or wasting endowments, which allow spending of the principal with certain restrictions (usually a maximum percentage each year or only after a set period of time). Endowments can be restricted, in which generated income can only be used for specified purposes (such as service delivery vs. administrative costs), or unrestricted. Funding mechanisms for capitalizing endowments include direct grants, the use of non-project assistance (NPA) conditionality, and debt swap arrangements (Weatherly, 1993).

As government and donor funding for NGOs becomes less certain, the idea of setting up endowments as a steady source of income has become more popular among NGOs and donors, including USAID. Sources of endowments include international foundations (e.g., Rockefeller, MacArthur Foundation), bilateral government agencies (e.g., USAID), and private individuals. The U.S. Foreign Assistance Act now allows USAID to create local currency endowments with grant money from either development assistance or economic support funds (Weatherly, 1993). USAID’s efforts in the promotion of endowments for health or population NGOs found in the literature include the development of a manual for family planning NGOs entitled “Endowments as a Tool for Financial Sustainability” and a seminar on endowments, both of which were developed by the PROFIT Project. In the environmental sector, USAID manages the EPAT Environmental Endowments Initiative, funded by the Africa Bureau, which has developed guidelines for endowments and for endowed foundations in Africa.

Only a few examples of endowments owned by NGOs working in the health and population sector were found in the literature:

- ▲ The VHS Hospital in Madras, India has an endowment which provides it with a substantial, steady source of income through its interest income, which in 1987-88 made up 13 percent of the hospital's total revenues;
- ▲ The Indian NGO, Rural Unit for Health and Social Affairs (RUHSA), which works in a number of social service sectors including health, set up an endowment through its founding organization, Christian Medical College in Vellore, using donated funds. The endowment provided an estimated 19 percent of the organization's total income in 1985-86 (Sohoni, 1987);
- ▲ USAID has established an unrestricted endowment for PROFAMILIA in Colombia, a leading provider of family planning services in that country; and
- ▲ USAID/Bolivia provided a \$5 million grant to PROCOSI, a consortium of international and Bolivian NGOs. PROCOSI has used the grant to arrange a debt swap that netted approximately \$8.5 million in local currency for the establishment of an endowment.

USAID established an endowment for PROSALUD, also in Bolivia, to allow it to cover future operational deficits while still maintaining its mission of serving a largely low-income population. The endowment provides a total of \$5.5 million over a four-year period to capitalize the endowment fund, which would be provided in yearly installments on the condition that PROSALUD meets certain performance criteria, such as achieving a certain level of cost recovery, expanding services, and satisfactorily managing its finances. Financial projections conducted by PHR estimate that, even with drawdowns to cover deficits, the fund would continue to grow once USAID funding has ceased (Holley, 1996).

2.1.7 Contributions by Associations and Employers

Some employers and associations contribute to NGO-run health programs other than through pre-payment and insurance schemes. In an association of tea growers in India, UPASI, membership subscriptions from private tea estates constitute the major funding source of the association's labor welfare scheme, which provides health care services to workers and their families. Village milk societies contribute a substantial amount of revenues for the health services provided by the Tribovandas Foundation. Another example is the voucher program run by PROFAMILIA, the Dominican family planning NGO. In this program, workers' associations finance vouchers that are distributed to poor women by community-based distribution (CBD) volunteers and allow these women to receive free services from affiliated health providers. The providers then redeem the vouchers through PROFAMILIA for an agreed-upon fee.

2.1.8 Savings through Cost Containment Measures and Efficiency Improvements

To complement revenue-generating activities, some NGOs have found innovative ways to keep costs low and/or to increase the efficiency of their service delivery programs. Some of these methods are:

Offering Incentives to Health Workers

Many NGOs offer financial incentives to health workers both to increase productivity and to keep salary costs low. In some cases, health workers get to keep all or a portion of the user fees collected for consultations and/or the profits from drugs and other products. The health promoters employed by Guatesalud, for instance, are allowed to keep the fees charged for consultations at most clinics, in addition to the salaries that are paid by the farm owners. The community health workers and traditional midwives employed by the Comprehensive Health and Child Development Project (CHDP) run by the Ashish Gram Rachna Trust in Maharashtra, India, can keep the money that they collect for drugs and immunizations, which accounts for around 60 percent of their total income. This provides these workers with a strong incentive to seek out and follow up clients for immunizations. The traditional midwives (*dais*) are also given an honorarium for each mother who completes a package of antenatal and postnatal care and whose child survives for three months (Berman and Dave, 1996). An incentive to the low-salaried doctors of the Aravind Eye Hospital in India, as mentioned earlier, is their ownership of the hospital's pharmacy and optics shop, the profits of which are shared.

PROSALUD has an employee incentive system in which bonuses are awarded to the full-time (non-specialist) physicians and other clinic staff. Bonuses are based on the financial performance of all of the clinic's 11 cost centers, with the exception of the pharmacy (thus providing no incentive to over-prescribe drugs). In each clinic, 30 percent of the monies left in the revenue 'pot' after subtracting the minimum performance benchmark are split among staff, with the physician getting 30 percent of this amount and the other staff members splitting the remaining 70 percent based on their salary levels. These bonuses reportedly make up about 10 percent of the employees' total compensation (Fiedler, 1990).

Use of Volunteer Workers

In order to contain costs, many health NGOs use volunteers, although efficiency often suffers due to a lack of incentive to work and high turnover rates. Donated labor by physicians working for the VHS Hospital in India, as mentioned in *Section 2.1.4*, does seem to be a successful means of cost containment.

Creating "Multi-Function" Positions and Other Means to Reduce Personnel Costs

To reduce personnel costs, PROSALUD decided to replace the night watchmen at its clinics with nurse auxiliaries, who both provide health services and serve as night watch persons. This approach has not only reduced personnel costs, it has also allowed services to expand by creating 24-hour care centers. PROSALUD also saves personnel costs by sharing some of its clinic staff, particularly lab technicians, among its various clinics. The Indian NGO, Sewagram, saves administrative costs by having the community health workers themselves be responsible for selling

the grain they collect for membership fees on the open market and for buying the drugs they need for their patients with the money from the sale of grain.

2.2 Efforts to Improve Sustainability through Increased Institutional and Management Capacity

In addition to efforts aimed at improving financial sustainability, many health NGOs are trying to improve their sustainability by strengthening their institutional and management capabilities. Examples of these efforts include: creation of NGO umbrella organizations and coordinating bodies, creation of strong leadership bodies, development of strong management information systems (MIS), decentralized management, innovative marketing techniques, and strategic and business planning.

2.2.1 Creation of NGO Umbrella Organizations and Coordinating Bodies

There are a growing number of national NGO coordinating bodies or umbrella organizations in developing countries, many of which have been created in recent years as a conduit for distributing financial and technical assistance by international donor agencies or through the encouragement of national governments. Stremlau defines NGO coordinating bodies (in contrast to informal NGO networks) as “formally-constituted” institutions that have a board of directors or other formal representative structure, receive financial support from member organizations through membership dues, and have a paid staff and office (Stremlau, 1987). Stremlau distinguishes between “broad-based” umbrella groups, to which any NGO operating in the country can belong, and sector-specific bodies, that consist of agencies working in specific sectors, such as health.

Examples of broad-based umbrella organizations are: the *Comite de Coordination des Actions des Organisations Non-Gouvernementales* (CCA-ONG) of Mali, the *Centro Dominicano de Organizaciones de Interes Social* (CEDOIS) in the Dominican Republic, PROCOSI in Bolivia, and the Haitian Association of Voluntary Agencies (HAVA). Examples of health sector-specific umbrella groups are: Voluntary Health Association of India (VHAI) and the Voluntary Health Services Society in Bangladesh. An important sub-set of sector-specific umbrella groups, especially in Africa, and amongst the oldest and most established, consists of church-run organizations, such as Christian Association of Malawi (CHAM), Church Medical Association of Zambia (CMAZ), and Christian Association of Ghana (CHAG).

NGO umbrella groups play an important role in serving as an intermediary between NGOs and governments in negotiating collaborating arrangements and financial support, and as mentioned above, as a vehicle for international donors to provide technical and financial support to a large number of NGOs at the same time. In these instances, the umbrella group receives a block grant from the donor and in turn, serves as a grant-maker by providing small sub-grants to individual NGOs. Increasingly, however, many umbrella groups are providing services to their members in an effort to improve their management and programmatic capabilities and to “professionalize” them. These services can include technical assistance and training in different aspects of planning and management such as program design, evaluation, accounting and organizational development, the development and testing of new methodologies, and bulk purchasing and management of drugs and medical supplies as a means of cutting costs.

The Social Service National Coordinating Council (SSNCC) of Nepal, for instance, has technical and training divisions to help strengthen the management and technical capabilities of its member NGOs. PROCOSI of Bolivia, HAVA in Haiti and CEDOIS in the Dominican Republic all place a priority on providing training and technical assistance to members to increase their program effectiveness. Another common function of umbrella groups that can strengthen NGO capabilities is to exchange information, share experiences, and discuss common problems. For example, VHAI co-sponsored a national workshop on health financing in the voluntary sector, during which findings from the Ford Foundation case studies cited in this review were discussed in length.

Despite the growing number of NGO coordinating bodies and their increasing role in a number of places, there is little concrete evidence thus far that they play an important role in strengthening NGOs' capabilities and increasing their sustainability. Three studies of NGO coordinating bodies in Africa, Asia, and Latin America, commissioned by PACT in the early 1980s, concluded that these bodies "were playing only marginal roles in NGO development" (Stremlau, 1987). This is likely to be due, in part, to the weak institutional capabilities and unstable financing of many of the umbrella groups themselves, especially those in Africa. The sustainability study of 16 health and family planning NGOs in Nigeria, commissioned by the Initiatives Project, did find that sustainable NGOs were more likely to receive concrete services, such as bulk purchasing and training from their umbrella organizations, than were NGOs found to be unsustainable (Hare, 1996).

2.2.2 Creation of Strong Leadership Bodies

One feature of "mature" organizations shown on several of the institutional development models created as assessment and planning tools for NGOs (including those shown in *Annex A*) is a strong board of directors which is responsible for helping to define the organization's mission, formulating policy, overseeing the functions of the NGO, and promoting and securing funding for the organization. A board made up of national leaders in the field and/or other well-connected individuals can play an important marketing role by helping to establish the organization's reputation, by raising funds both domestically and internationally, and by increasing the demand for its services. Many health sector NGOs described in the literature have weak, if any, boards of directors. Some boards, such as that of Rxiiin Tnamet in Guatemalan, are made up entirely of program staff, thus limiting its outside influence. Guatesalud, on the other hand, has a board made up of members external to the organization, but rarely uses their business skills and gives them virtually no power.

PROSALUD has a strong leadership structure, consisting of a General Assembly of Associates and a Board of Directors elected by the General Assembly. The General Assembly determines the general policies of the organization and oversees the Board of Directors and the executive staff members. The Board formulates and approves policies, including pricing policies, reviews reports from the Executive Director, and oversees the general functioning of the organization. To ensure close links with the communities in which PROSALUD serves, each of the organization's health centers also has a community board which helps plan and develop the center's activities.

2.2.3 Development of Strong Management Information Systems (MIS)

Examples of innovative MIS used by NGOs to monitor and improve the performance and efficiency of their activities include the rural-based Comprehensive Health and Development Project (CHDP) in Maharashtra, India that has developed a village-level register system to track the preventive health needs of individual households (e.g., remaining immunizations). Community health workers and *dais* use this system to improve the targeting and efficiency of their activities (Berman and Dave, 1996).

PSS in India has an elaborate MIS used to monitor the performance, efficiency, and financial accountability of its individual clinics, which are each treated as separate cost centers and are delegated a considerable amount of financial responsibility. A series of financial, productivity, and performance indicators are constructed at the organization's central office from financial and service data provided by each clinic on a monthly basis. Financial indicators include the cost per "Medical Termination of Pregnancy (MTP) equivalent" for abortions and sterilizations (using a conversion factor), the ratio of salary costs to fee income, the fee income per full-time staff equivalent, and, for family planning services, the cost per Couple Years of Protection (CYP). Productivity and performance indicators developed for each clinic include the number of MTP equivalents per full-time staff equivalent and the number of CYP. The central office uses these indicators to make management decisions and to compare the performance of the different clinics.

PROSALUD's MIS constructs three sets of monitoring and evaluation indicators for each of its clinics: 1) service indicators ("Primary Care Information"), which measure utilization, productivity, coverage, continuity of care, and quality of care²; 2) "Primary Care Management" indicators that relate the service indicators to such inputs as numbers of personnel and medicines as a means of monitoring efficiency; and 3) "Primary Care Accounting" indicators that track the costs and expenditures of health activities. The 55 service indicators are used as the basis for developing each clinic's annual plan and budget. Each month, the medical directors of the clinics receive graphs from the organization's Management Services Unit (MSU) comparing planned and actual provision by service for the month and the year to date, based on these indicators. PROSALUD also conducts an evaluation of each clinic by activity every three months using these indicators.

2.2.4 Decentralized Management

A few examples were found in this review of organizations that have decentralized management and decision-making at the local or facility level as a means of improving planning, accountability, and efficiency. YKB in Indonesia runs a network of family planning clinics and has given its clinic directors greater authority to establish services and allocate resources, while taking on greater responsibility for generating revenues. And, as previously mentioned, each PROSALUD clinic is heavily involved in planning its activities and in developing its budget each year.

² Examples are: average number of pre-natal, peri-natal, and well-baby visits per birth and percentage of various immunizations received before a child's first birthday.

2.2.5 Innovative Marketing Techniques

The lack of skills and experience in marketing and market analysis is a common weak point among many health and population NGOs. Some NGOs, however, have made an effort, often with donor technical and financial support, to use innovative marketing techniques to expand their coverage. PROSALUD at one point carried out a series of health fairs at its clinics to promote and educate the population on the importance of preventive health care. Activities at the fairs included measuring people's height and weight, cooking competitions among mother's clubs, and other forms of educational entertainment. Although these fairs resulted in sharp short-term increases in patient volume, which were enough to cover the costs of the fairs, the fairs were short-lived and have not been repeated very often. Since 1985 PROSALUD has carried out marketing studies at potential clinic sites to determine where to locate clinics. PROSALUD also plans to step up its marketing efforts through such approaches as advertising and door-to-door campaigns in order to target specific populations.

With assistance from the Enterprise Project, the Brazilian family planning NGO, BEMFAM, developed a successful marketing strategy for its new cervical cancer screening lab. This strategy involved telemarketing, direct mail, and personal interviews with physicians, who would be critical in referring patients, to find out their specific needs and problems.

Other marketing strategies, such as the fund-raising events sponsored by several Indian NGOs, differential pricing strategies (such as charging clients in poor areas less than those in wealthier areas and tying charges to distance traveled by the patient), and community-based preventive health campaigns, have been described above.

2.2.6 Strategic and Business Planning

Some NGOs, often with technical assistance from donor agencies, undertake formal strategic, business, and financial planning exercises in order to expand their markets, anticipate and respond to negative trends (such as reductions in donor funding), forecast future costs and revenues, etc. For example, the MSU officers of PROSALUD develop a rolling three-year strategic plan, based on in-depth discussion and analyses of likely future scenarios regarding economic, political, social, and health developments, upon which the organization's annual operational plans and those of individual clinics are based. With assistance from PHR, PROSALUD has also carried out a long-term, comprehensive financial planning exercise, using alternative cost and revenue projections, as part of its development of a proposal for an endowment funded by USAID. Such technical assistance projects as the Enterprise Program, its successor, the PROFIT Project, as well as the Initiatives project, have helped their partner NGOs develop strategic and business plans to improve their planning capabilities and, ultimately, their sustainability.

2.3 Efforts to Improve Technical and Programmatic Sustainability

One of the main strengths and selling points of many health and population NGOs operating in developing countries is the perception among the populations they serve that the quality of their services is higher than that found in government facilities. Several NGOs have developed strong

technical training programs and other quality control measures to ensure and maintain a higher level of quality, as discussed briefly below.

2.3.1 Training Programs

The Guatemalan NGO, Guatesalud, runs a month-long, high-quality pre-service training program for its health promoters, who come from the *fincas* themselves and are sponsored by the farm communities. Promoter candidates are not required to have completed any particular level of formal education, but must have certain minimum reading, writing, and math skills. The course, which uses training materials based on the book *Where There is No Doctor* is taught by the organization's founders (both physicians). The course combines basic training in anatomy, physiology, and building diagnostic and problem-solving skills, with intensive hands-on training in medical procedures such as physical examinations, taking blood smears for malaria, and administering IV and injections. On-the-job, follow-up training of the promoters is provided by the staff physicians who supervise them. The health promoters also are required to take one-week refresher courses each year to improve their skills in specific areas. For example, courses have been offered in family planning methods, diagnosis and treatment of common diseases, and the use of a survey instrument for conducting a community health diagnosis. The staff doctors who supervise the promoters also attend these in-service courses.

PROSALUD's strong in-service training program for its clinical staff (doctors, nurses, and nurse-auxiliaries) is considered a critical tool in improving the quality of care provided at its clinics and in maintaining staff interest and morale. The organization has a separate training budget, and develops an annual action plan for its training activities, which identifies their objectives, amount of contact hours, and trainers (who are often selected from its clinic staff). Training is provided in a broad range of clinical and management areas, including the provision of maternal and child health care, infection control, antibiotic therapy, social marketing, management, community organizing, selection and training of health promoters, and the use of charts and clinic forms. Training is also provided in the human relations aspects of providing quality health care. Easy-to-follow, well-written manuals have been developed for many of these training activities. Given the increasing difficulty and expense of training its staff as the organization expands, PROSALUD has begun to develop training modules for "long-distance" clinical and management training to be provided at the regional level.

2.3.2 Quality Control Methods

To ensure high quality of care, PROSALUD has developed a full range of diagnostic and treatment protocols and clinical procedures to be followed by its clinic staff. The organization has developed a series of manuals for supervisors and plans to establish "Quality Circles" made up of clinic staff to improve the quality of care and management of each of its clinics. Quality is also controlled via the organization's self-evaluation and peer-review activities which take place monthly during meetings of all medical directors. These reviews use clinic-specific data based on the service, financial, and management indicators described in *Section 2.2*.

Guatesalud places considerable emphasis on the selection of its health promoters, which takes place with heavy input from the communities, as a means of ensuring the success of its clinics. To

maintain the quality of care provided by the promoters, the organization requires staff doctors to review every two weeks the patient records, written by the promoters, to check for completeness, accuracy, correctness of the diagnosis, and appropriateness of the treatment given. The doctors then discuss these records with the promoters. When promoters are uncertain about a diagnosis or treatment to prescribe, they often ask patients to come to the clinics during the doctors' bi-weekly visits so that the doctors can review and follow-up the case.

3. Efforts by Donors and Cooperating Agencies to Help Improve the Sustainability of Health and Population Sector NGOs

In recent years, international donor agencies have looked increasingly towards voluntary organizations—both international PVOs, such as Save the Children and CARE, as well as indigenous NGOs in developing countries—as vehicles for providing development assistance in health and population. NGOs and PVOs are often viewed as more flexible than government agencies. Their ability to forge close links with communities is often considered an advantage. NGOs are also increasingly used by donors to provide assistance in countries where the donor government does not wish to support the host government, as was the case between the US and both Haiti and Nigeria.

The increased involvement of indigenous NGOs in foreign assistance projects has led to some concerted efforts by donors to strengthen the capacities and increase the long-term sustainability of these NGOs. Efforts by donors to focus on capacity-building and sustainability of local NGOs can be divided into four categories: 1) donor projects aimed at creating indigenous, sustainable NGOs; 2) PVO/NGO umbrella or co-financing projects; 3) centrally-funded projects that have as a major goal improving the capabilities and sustainability of local NGOs and other private sector organizations; and 4) sectoral projects that include NGO participation.

3.1 NGO-Creating Projects in the Health and Population Sectors

The Self-Financing Primary Health Care Project, begun in 1983 by USAID/Bolivia, resulted in the creation of the Bolivian NGO, PROSALUD, which obtained legal status as an indigenous non-profit organization in 1985. USAID's aim in developing this project was to develop and test an organizational model of providing self-financing primary health care services to low and middle-income populations in urban and peri-urban areas. PROSALUD has been considered by USAID and several independent evaluators as a great success and is being replicated elsewhere; the USAID-funded SHIPS Project in Peru which began in 1994 has created the organization, MAXSALUD, based on the PROSALUD model, and USAID/Zambia and the Zambian government are currently assessing the feasibility of developing a similar organization.

3.2 NGO Umbrella and Co-Financing Projects

USAID has funded a number of PVO/NGO co-financing or umbrella projects in the last 12 years. Umbrella projects are a means through which USAID can support a number of agencies at a time under a single funding obligation through a series of sub-grants. These projects are directly

managed by USAID Mission personnel or by U.S.-based PVOs, who provide and manage the subgrants to other PVOs and to local NGOs. An assessment of umbrella projects in Africa conducted in 1992 for USAID's Africa Bureau found that institution-strengthening of local NGOs was not the focus of many of these projects and its importance has frequently been undervalued (Otto and Drabek, 1992). However, some of these projects, including those considered the most successful, are placing more and more emphasis and resources in building up the capabilities of local NGOs to increase their sustainability. Some of these projects require that local NGOs be paired with U.S.-based PVOs as a means of building the institutional capacities of the local organizations. Some umbrella projects, such as the Mali PVO Co-Financing Project managed by Save the Children (U.S.), work with the country's NGO umbrella organization (CCA-ONG). Institutional-building activities of these projects include on-the-job and formal training in such areas as project design, project management, proposal writing, financial management, and technical aspects of project implementation. How much attention is given to the financial sustainability of NGOs in these projects, however, is not clear. Examples of umbrella projects working in the health sector that conduct institution-strengthening activities of local NGOs are:

- ▲ The **Senegal PVO/NGO Support Project**, begun in 1991 and managed by the American PVO, New TransCentury Foundation, provides subgrants to established PVOs and NGOs and "micro-grants" to small regional and community-based NGOs in several development sectors, including primary health care and family planning. In addition to managing subgrants, this eight-year project provides considerable training and technical assistance to local NGOs and NGO associations to improve their capacity to plan, design, and implement sustainable development activities.
- ▲ The nine-year **Services for Health, Agriculture, Rural, and Enterprise Development (SHARED) Project in Malawi**, managed by World Learning, helps to strengthen the capacity of local NGOs through small institutional development grants, partnerships with U.S. PVOs, training, and technical assistance. Grants are also given to U.S.-based PVOs, which are required to provide significant institutional support to Malawian NGOs.
- ▲ The **Mali PVO Co-Financing Project** provides grants to U.S. PVOs to work closely with local NGOs to improve their institutional capacities in the areas of child survival, natural resource management, and small enterprise development. As part of its efforts to strengthen local NGOs, the project created coordinating committees called *groupes pivots* for each of the three sectors in which it works. The *groupes pivots*, which are made up of the "lead sector PVO," local NGOs, and outside specialists, develop Strategic Action Plans for the PVOs and NGOs working within their sector.

The Africa Bureau study of umbrella projects in Africa found common problems with these projects that limit their effectiveness. These include: 1) the lack of assessments of NGO capabilities before providing them with subgrants, and consequently over-estimating their capacity to expand their activities and to manage relatively high amounts of donor funding; 2) the lack of indicators to measure and evaluate institution-building of NGOs; and 3) the pressure, in many cases, to spend money quickly and to produce rapid results, which can discourage the often slower process of institution-strengthening essential for the long-term, post-project sustainability of the local NGOs. Some of the newer umbrella projects are attempting to address these problems by increasing the length of the project (e.g., to 10 years or so), focusing more on capacity-building of local NGOs and fostering partnerships between U.S. PVOs and local NGOs.

3.3 Centrally-Funded Projects that Focus on Capacity-Building and Sustainability of NGOs and Other Private Sector Organizations

While many technical assistance health and population projects are involved in capacity-building of indigenous NGOs through collaboration on field activities, grant programs, or training activities, a smaller number of projects have improved the capacity and sustainability of local NGOs as their major focus. These projects include:

- ▲ The **Initiatives** Project is a five-year USAID-funded demonstration project that supports the development of private sector organizations that deliver health services to low-income populations. The project has provided technical assistance in strategic planning, the development of financial plans and projections, financial management and information system development, and other institution-strengthening activities to NGOs and other private sector groups in Ghana, Nigeria, Ecuador, and Guatemala. In Nigeria, Initiatives is carrying out an NGO Sustainability Technical Assistance Program, which began with an assessment of the financial sustainability of 16 indigenous NGOs working in health and population and now involves assisting 30 NGOs to enhance their capacity to be financially sustainable once donor support is withdrawn. Among Initiatives' research activities is a series of five case studies of relatively new private organizations, including two NGOs, that provide basic health services to low-income populations to examine the factors influencing the success and viability of these organizations.
- ▲ The **Strategic Planning and Management for Francophone African NGOs** is a pilot project funded by the Economic Development Institute (EDI) of the World Bank that provides technical assistance and training through regional workshops, in strategic planning to NGOs in Benin, Burkina Faso, Mali, and Niger. Senior African consultants are paired with more junior counterparts during training activities to increase the in-country training capacities.
- ▲ The USAID-funded **PROFIT** Project and its predecessor, the **Enterprise** Program, both aimed at increasing private sector participation in family planning, have helped NGOs providing family planning services to improve their managerial and technical capabilities and to achieve greater financial self-reliance and sustainability. Both projects have provided technical assistance to specific NGOs in strategic and business planning, marketing and fund-raising, the development of income-generating activities, and improving their technical services. In addition, these projects have produced materials to broaden general knowledge on sustainability and to assist indigenous organizations in planning ways to become more sustainable. The Enterprise Program produced the manual, *Achieving Financial Self-Reliance: A Manual for Managers of Non-Governmental Organizations*, and the report, *Promoting NGO Sustainability: The Lessons of Enterprise*. PROFIT has conducted assessments of sustainability of NGOs in specific countries, and produced the manual, *Endowments as a Tool for Financial Sustainability: A Manual for NGOs*.
- ▲ The **Transition Project** is a five-year project aimed at making selected IPPF-affiliated family planning NGOs in Latin America and the Caribbean that are currently receiving financial assistance from USAID self-sufficient within the life of the project. The project

has developed a framework to evaluate sustainability and publishes a newsletter, “Sustainability Matters,” that describes the project’s sustainability-related activities.

- ▲ Several USAID-funded projects that are aimed primarily at improving the capabilities and sustainability of U.S.-based PVOs, also assist indigenous NGOs. The USAID-funded **PVO/NGO Initiatives Project (PIP)**, for instance, which is aimed at increasing the collaboration between USAID, U.S.-based PVOs, and local NGOs in more than 20 sub-Saharan African countries, provides assistance to indigenous NGOs to increase their technical and institutional capabilities. PIP also has developed several case studies and research papers on NGOs, including the study of African PVO/NGO umbrella projects. The **Global Excellence in Management (GEM) Initiative**, funded by the USAID Office of Private and Voluntary Cooperation (PVC), provides training in institutional analysis and organization development to developing country NGOs and U.S. PVOs. Although the **Sustainable Development Services Project** is also funded by USAID’s PVC Office, it targets U.S. PVOs that provide health, nutrition, and family planning services and assists PVOs in strategic planning to achieve greater sustainability and the development of sustainability tools (e.g., case studies, planning frameworks, and guidelines).
- ▲ Several USAID cooperating agencies are **developing indicators** to assess, monitor, and evaluate the sustainability of family planning programs, including those run by NGOs. The Family Planning Management Development (FPMD) Project is spearheading an initiative to develop facility-level sustainability indicators for family planning organizations, while the Evaluation Project is developing country-level sustainability indicators. In Bangladesh, FPMD has developed and pilot-tested facility-level sustainability indicators (as well as indicators to measure quality and expansion of coverage) to help five U.S. cooperating agencies (CAs) support 115 local family planning NGOs. The project has developed a management information system based on these indicators. The sustainability indicators address the institutional, managerial, and financial aspects of sustainability. FPMD also runs a Population and Reproductive Health Section Task Force on Management and Sustainability.

The FPMD Project is currently developing an institutional development matrix to be used as a tool to assess the management sustainability of family planning organizations (the matrix is shown in Annex C). As part of this process, the project ran an on-line “sustain” conference in the fall of 1996 during which a number of CAs discussed the proposed matrix, which has been subsequently revised and is being tested in several family planning organizations in Latin America. The electronic conference has recently been reopened.

3.4 Sectoral Projects with NGO Participation

Many bilateral development projects involve the participation and presumably capacity-building of indigenous NGOs. One USAID example is the Bangladesh Family Planning and Health Services Project, which supports both indigenous NGOs and PVOs that provide family planning services. The World Bank has also increasingly involved indigenous NGOs in its development projects; by fiscal year 1994, 50 percent of the projects approved by the Bank’s Board involved NGO participation in their design.

Annex A: List of Persons Interviewed or Contacted

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Annex B: Matrices of Sustainability Indicators

Institutional Development/Sustainability Status Assessment Instrument

1. General Information:

Date: _____

Name of Institution: _____

Address: _____

Founding Date: _____

Type of FP/RH Activity

Service Delivery FP Only Other Health

IEC

Training

Other _____

Geographical Focus: National Local

Activities:

Main Focus: _____

FP Services: _____

of Settings: _____

Number of Staff (FTEs)

Paid _____

Volunteers _____

Annual Budget (\$1000)

		<5%	5-15%	15-30%	30-60%	>60%
Sources	Clients	_____	_____	_____	_____	_____
	Donors	_____	_____	_____	_____	_____
	Public Funds	_____	_____	_____	_____	_____
	Other (_____)	_____	_____	_____	_____	_____

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2. Internal Management Characteristics

This section of the instrument obtains general information about the organization's characteristics with respect to a number of essential management components. For each management component, circle the statement that most closely reflects the present status of the organization. In the comments section, please indicate the observations which led you to the selected stage and other information related to the specific management component and the reference criteria used.

Management Component	1	2	3	4
Mission	Undefined or activities not related to mission	Focused commitment to development of FP/RH service/some idiosyncratic activities	Defined mission drives many activities	Mission drives all activities
Comments:				
Strategy	Opportunistic/spawned by single event	Strategy with some clear link to FP/RH activities	Product expansion/target markets well-defined	Organizational strategies linked to mission
Comments:				
Structure	Ad hoc/project-driven/hierarchical with no delegation	Discernable structure Some delegation	Formal structure Staff has some decision-making role	Policy-making board/Staff manages/Significant delegation
Comments:				
Systems: Collection and Use of Information	No routine data collection	Ad hoc reports based on operating information	Regular flow of info generated/supports some management functions	Data acquisition routinely used to support all management functions and policy decisions
Comments:				

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Management Component	1	2	3	4
Systems: Commodities	Ad hoc supply management	Rudimentary supplies logistics system exists	Fully functioning logistics system dependent on external technical support	Fully functioning logistics system/no external technical support needed
Comments:				
Systems: Financial Management	Cash recording based on donor requirements	Double entry financial accounting/no costing analysis	System produces income/revenue data and cash flow analysis/focused on cost centers	Unit cost management/key information used on a regular frequent basis
Comments:				
Systems: Revenues	Single ad hoc initial source of revenues/little or no client support	Growing revenues/local sources	Multiple revenue sources/client support is significant (where applicable)	Stable revenues/long-term committed/dependable sources of funding
Comments:				
Systems: Planning	Ad hoc/individualistic	Some priorities which reflect source availability	Annual projection of budgets and priorities/Strategic planning	Strategic plan followed and monitored and revised every 3-5 years
Comments:				
Systems: Human Resources	Project/donor driven No formal general procedures	Personnel policies exist/some job descriptions/some specialized personnel for key positions	Consistent use of personnel policies and procedures throughout the organization	Accurate and regularly revised job descriptions/all managers use same rules and procedures/planning and review systems used to motivate performance
Comments:				

OD/SS Assessment Instrument
FPMD Field Test Version, March 1997

This section of the instrument addresses the relationship of the organization to the national population program.

1. What is the relationship of the organization to the national program?

	Yes	No
No direct involvement	_____	_____
Receives materials	_____	_____
Provides information	_____	_____
Some staff participation in program activities	_____	_____
Organization leadership actively involved	_____	_____
Organization has leadership role	_____	_____

2. (For organizations whose activities are directed at clients—service delivery, IEC, etc.) Please circle the statement that best describes the organization's role in achieving national program goals.

Program Goal				
Priority of target population	Not serving target population	Target population not major priority	Target population is organizational priority but not primary market	Target population is primary market
Quality		Participates in program's quality assurance activities	Sets/reinforces standards for high quality	Program reference site for high quality
Service volume for general population	Small, local market	Significant provider in single location	Major regional service provider	Major national provider
Service volume for target population	Not serving	Not a major provider in any market	Significant provider in some local markets—small national share	Major provider of services program-wide

Other Comments: @

Table B.1 Illustrative Stages of Institutional Development

Functional Area	Start-Up Organization	Developing Organizations	Mature Organizations
Leadership	Board non-existent or partially filled. Roles unclear. Single dynamic individual controlling most functions.	Board complete but not yet playing leadership role. Mission statement clarified internally, but not widely known by public.	Board made up of leaders in the field, conducts fundraising and directs policy. Mission clear to staff and outsiders.
Human Resources	Limited staff fulfilling responsibilities beyond their expertise. Limited communication between staff. Little or no training.	Better match between personnel and position requirements. Some resources for training. More participatory management style	Well-defined jobs with appropriately qualified staff. Long-term human resource development strategy in place. Delegation by senior management common.
Internal Administration	Administrative systems not formalized. Limited participation by beneficiaries in planning process. Program development largely donor-driven, project-by-project. Little or no monitoring and evaluation.	Basic administrative systems in place, if not consistently applied. Individual projects developed within the context of strategic planning. Evaluations conducted but not yet used as a management tool.	Administrative systems well-developed and functioning. Strategic planning carried out. Evaluations routine and MIS operational. Information used to develop new activities.
Financial Resources and Management	Funds solicited for one short-term project at a time - no steady source of funds for core costs. Financial controls inadequate and financial reporting weak.	Depend on single or limited donors. Basic financial system in place, but still experiencing problems with accuracy and timeliness.	Multiple donors. Funds accounted for separately and accurately. Significant percentage of core costs covered by locally generated resources (dues, fees, regular fundraising, etc.).
Service Delivery/ Technical Expertise	Good ideas but little operational experience. Agenda and services defined by managers and not by beneficiaries.	Improving targeting. Services defined with beneficiary input. Good technical skills in program areas.	Efficient delivery of appropriate services to well-defined beneficiaries. Cost recovery applied where possible. Exploring transfer of management responsibility to local organizations.
External Environment	Little or no collaboration with other NGOs or with government. Agenda largely donor-driven	Collaboration established within specific sectors of activity and geographic areas. Member of NGO coalition.	Seen as credible partner by government, donors, and other NGOs. Providing input into policy process on issues related to program areas.

Source: Adapted from materials developed by World Learning

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